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The Frequency of Occurrence of Five Factors Which Tend To Interfere With The Home Training of Pre-Kindergarten Mentally Handicapped Trainable Children

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THE FREQUENCY OF OCCURRENCE OF FIVE FACTORS WHICH TEND TO INTERFERE WITH THE HOME TRAINING OF PRE-KINDERGARTEN MENTALLY HANDICAPPED TRAINABLE CHILDREN

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ABSTRACT

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THE FREQUENCY OF OCCURRENCE OF FIVE FACTORS WHICH TEND TO INTERFERE WITH THE HOME TRAINING OF PRE-KINDERGARTEN MENTALLY HANDICAPPED TRAINABLE CHILDREN.
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The purpose of this study was to ascertain how frequently five factors, which tend to interfere with the home training of pre-kindergarten mentally handicapped trainable children occur. The five factors were: (1) the unrealistic search for medical or surgical cure, (2) the unawareness of the retarded child's trainability, (3) the interference with training on the part of relatives, neighbors, friends, and neighborhood children, (4) the emotional involvement of the parents with their retarded children, and (5) indifference to the need for training the child.

In order to obtain this information the following procedure was adopted:

1. The parents of fifteen trainable mentally retarded children, who were born between the beginning of 1935 and the end of 1945 and who are now resident at Winfield State Training School, were selected as subjects for this study. Only parents who had kept their children in the home for a sufficiently long period of time to have had an opportunity to train them were selected.

2. Information was obtained by collecting all pertinent data found in the case files of Winfield State Training School and be face to face interviews with the parents.

The findings indicated that the parents were not able to give their retarded children proper home training principally because there were no sources of helpful information available to them. In comparison with this fact the other factors studied played secondary roles in interfering with the home training of these children.

In view of these findings provisions for early recognition and accurate diagnosis of all retarded children should be made and some workable plan to give the parents regular and continued professional guidance in the training of their retarded children should be initiated.

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CHAPTER I

INTRODUCTION

The mentally retarded have always been a part of the human scene. Just as each generation has produced its outstanding individuals, whose superior mental and physical endowments have made them leaders and enabled them to march in the vanguard of whatever human progress was made, so also has each generation produced its mental defectives, who not only could not follow the leaders, but were even unable to keep pace with the led.

Our own generation is no exception. The National Association for Retarded Children, as reported by Kirk, Karnes, and Kirk, estimates that there are thirty individuals in every one thousand population of the United States who are mentally retarded, i. e., who have an IQ of 75 or less.[1] If this estimate is somewhere near correct then there are between four and a half and five million mental retardates in the forty-eight states and between fifty and sixty thousand in the State of Kansas alone. Unbelievable as these figures may sound to the uninitiated they are nevertheless in substantial agreement with most other estimates. The House Appropriations Committee of the 84th Congress estimated

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[1] Samuel A. Kirk, Merle B. Karnes, Winifred D. Kirk, You And Your Retarded Child. New York: The Macmillan Company, 1955, p. 8.

that there are between three and five million retarded individuals of all ages in the United States.[2]

It is not surprising, then, that the House Appropriations Committee referred to this as "a great and growing problem."[3] And because it is a great and growing problem, it is a problem that demands, not only of the parents and responsible relatives of these unfortunates, not only of those who are professionally concerned with their welfare, but of all citizens an earnest effort to find a solution.

In searching for a solution for this problem society has through the centuries put the basic question as to what to do about it in two ways. At times society has asked, "What shall we do with these people?", and at others, "What can we do for them?" History tells us, for example, that the Spartans dealt with the problem of idiocy "in the sternest eugenic fashion and obviously defective children are said to have been cast into the river or left to perish on the mountainside. The laws of Lycurgus countenanced the deliberate abandonment of idiots . . ."[4] With the coming of Christianity, with its emphasis upon the brotherhood of man and the sanctity of all human life a more humane treatment

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[2] "Health, Education and Welfare of Mentally Retarded Children", Bulletin of the Social Legislation Information Service. Issue No. 33 (84th Congress), Sept. 30, 1955, p. 1.

[3] Ibid. p. 1.

[4] S. P. Davies, Social Control of the Mentally Deficient. New York: Thomas Y. Crowell, 1930, pp. 14-15.

of the mentally defective also became more general, although this has by no means been uniform in all so-called Christian countries nor at all times during the Christian era.

At the present moment we are living in a time when the question, "What can we do for these unfortunates?" is being asked with renewed insistence. The question is being answered -- at least a beginning is being made to answer this question -- by positive action. The attack on the problem is at present a two-pronged one, the one medical and the other educational.

The medical attack upon the problem consists of research to find the various causes of mental retardation with a view to prevention and a possible reduction of the incidence of the condition, as well as discovering better methods of alleviating and treating the physical ills that so frequently accompany mental retardation. The educational attack has as its aim the education and training of the mentally retarded, and, if possible, to make them economically self sufficient, or at least to some extent economically useful and socially competent.[5]

Significance of This Study

This study, as its title indicates, concerns itself with the educational attack upon the problem of mental retardation. Much

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[5] For a rather thorough discussion of developments and trends in education for the mentally retarded see the article by Morvin A. Wirtz, "The Development of Current Thinking About Facilities For The Severely Mentally Retarded", American Journal of Mental Deficiency, Jan. 1956, pp. 492-507.

more is now being done educationally for the mentally retarded than was being done a few years ago. Morvin A. Wirtz summarizes as follows in the article referred to above:

> 1. The first provision for trainable mentally handicapped children in this country on a formal basis was the establishment of institutions. . . .
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> 2. The next main step in the provision of facilities for mentally retarded children was the establishment of public school classes for them. These classes, however, were established to provide training for the less severely handicapped. (Roughly the 50 to 75 group.) The growth of these classes has also been phenomenal. There were about four and one-half times as many children being educated in special classes for mentally retarded in 1954 as there were in 1922. There generally were no provisions made in public schools for the severely retarded, however.
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> 3. In the last five years there has been a trend toward making public school provisions for the trainable mentally handicapped children (the severely retarded group). Many parents, for a number of reasons, tend to reject the idea of placing their children in institutions or private schools. Instead, they prefer to keep the children at home and to hope that some provisions will be made in the community for them. This creates problems which parents recognize, but which are not solved by merely keeping the children at home. Because of these problems, many parents are insisting that public school provisions be made for their children.[6]

The Kansas State Legislature recognized the need for special classrooms, not only for the less severely mentally retarded, but also for the severely retarded when it enacted enabling legislation in 1951 for the establishment of special classrooms. There is at present, however, a shortage of properly trained teachers for these special classrooms, and this shortage is at present the chief obstacle to the rapid increase in the number of these facilities.

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[6] Morvin A. Wirtz, op. cit., p. 505

As soon as more teachers can be trained for this special kind of teaching the number of classrooms for the severely retarded can be expected to rise rapidly.

However, even if we could assume that in the not too distant future special classes for all of the trainable as well as for the educable mentally retarded would be established, this still would not constitute a total nor a sufficient educational program for them. Education and training do not begin in the classroom, but in the home. The child does not begin to learn at the time he is able to go to school for the first time, but from the day of his birth. And in this pre-school period the teachers are the parents, the older siblings, if there are any, the older boy or girl next door, later the children in the neighborhood plus their parents, in short, all of the people plus the total environment in which the child finds himself. For the average, or above average child, most homes, most neighborhoods provide an environment filled with many and varied opportunities to learn and to grow mentally, morally, and emotionally, as well as physically. This is not true for the retarded child, and the more severely retarded he is the less true it becomes.

First of all the retarded child is almost certain to have a relationship with his parents that is radically different from that of the average child. The average child is a more or less known quantity to his parents. Either they have had older children themselves, or they have seen younger sisters or brothers

grow from infancy, or the child of a neighbor, or they can get information as to what to expect from their child and when to expect it from books, magazine articles, and experienced neighbors. And when the average child first notices people, or pulls himself up in his crib, creeps on the floor, smiles, says his first word or what sounds like it, and does all of the other things that children do, he is usually a delight and a source of pride and joy for his parents and siblings and relatives. His first experience of them is of this nature. But when the retarded child does not notice people, does not pull himself up in his crib, nor creep on the floor, nor smile, nor say anything, nor make the progress that the baby next door, or two or three houses down the block, is making, he becomes a source of anxiety, of many fears that both mother and father at first try to deny even to themselves, of disappointment, and, in some cases, even of shame and feelings of guilt. Children, even small children, feel the reactions of their parents and of older people toward them very keenly. Most every one who has been around children to any extent knows how the eighteen to twenty-four month old will play up to his audience when he senses that what he is doing makes him the center of attraction. For the retarded child, however, there can be no feeling that older people delight in him even after he, at his slower rate of development, is able to sense their moods. Since he also has a real need for the attention and approval of his parents and others, but is not clever enough to win their approval, he uncon-

sciously resorts to misbehavior in order to become the center of attention. He learns that if he screams, kicks, or otherwise misbehaves he will receive attention. When the average child gets older there are other children with whom he can play, and from them learn many things, at first by imitation, and later by word of mouth. But by the time the retarded child becomes aware of other children and has the mental ability to play with them his body usually has already grown too large and his years too many to play with average children of comparable mental age. And so he's a misfit, he doesn't belong, he is without companions. Moreover, during the early months of his life, when the parents are still either unaware of, or still denying to themselves, the fact that this is a below average child, they are all too apt to push the child beyond his capacity to learn, and one frustrating experience after another is apt to become the order of his days; and when the parents do begin to realize that their child is retarded, they tend to either overprotect him, or to reject him, or, because they now consider it a hopeless undertaking, do not even attempt such training as might be advantageously undertaken. The goal of all education is to help the learner to develop and make use of his innate potentialities to the fullest possible extent. This process of developing and learning to make use of innate potentialities does not begin when the child is ready to go to school, but it starts from the first hour of life. For the average child most homes provide a setting in which this development does take place, but for

the retarded child there is less opportunity, as a rule, to develop even such limited potential as he does have. It would seem evident that just as the retarded child needs special classrooms if he is to learn at all, so does he need a special kind of home before he enters the special classroom, so that his retardation does not serve to deny to him the development of such potential as he does have.

For these reasons it would seem that any studies which promise to increase our understanding of the special difficulties and problems which parents of retarded children face and try to solve in the pre-kindergarten years of their child's life should be valuable contributions and helps in our efforts to answer the question, "What can we do for these unfortunates?" in an educational way. This study is an effort in this direction.

The Problem.

Anyone who finds himself in daily contact with retarded children in an institutional setting for some time, becomes aware of the fact that retarded children are also subject to emotional difficulties which often express themselves in behavior patterns and often make training and habilitation vastly more difficult and, at times, even impossible. These emotional difficulties are undoubtedly due to the situation in the home and the child's relationship with his parents and others during the very early formative years. And when, in addition to contacts with retarded

children one also has opportunity to interview many parents of institutionalized as well as uninstitutionalized retarded children one begins to see that there are actually certain types of difficulties that parents must overcome if the child is not to develop emotional difficulties and if he is to grow mentally and emotionally at a pace commensurate with such innate potential as he does have. Each one of these difficulties appears as a factor which tends, then, to interfere with the proper home training of the pre-kindergarten retarded child. Of the fact that these factors are present there is no doubt. The problem is to know how prevalent each one of them is in comparison with the others and what their relationship is to each other. If this can be learned, then methods and procedures designed to give the parents help in their difficult task of bringing up their retarded children could be devised and put to use.

Scope of The Study.

This study has not been designed to be an exhaustive and detailed investigation of all of the difficulties faced by parents of retarded children during the pre-kindergarten years, but is limited to an investigation of the prevalence of five types of difficulties which could or must be outstanding factors in contributing to emotional maladjustment of the retarded child with its consequent unacceptable behavior patterns and to the actual lack of intelligent training of the child during the first five

to ten years of his life. Moreover, no claim is made that this is anything like a complete study of even these five factors. Fifteen subjects who are now definitely known to belong in the classification of trainable mentally retarded have been selected, and the conditions that obtained in their homes during the early years of their lives have been investigated so as to find out whether one or more of these five factors had any part in depriving the child of any training he should have had. In other words, is it possible that any one or more of these fifteen subjects would now be socially more competent and economically more useful, and was it the presence of one or more of these factors that contributed to this lack of development? What general conclusions can be drawn from so small a sample will surely be questionable, but the study may serve to indicate whether a larger sample and a more detailed and thorough study would be promising.

Terminology.

The long used terms moron, imbecile, and idiot have by now almost disappeared from the literature on mental retardation. Instead of these, new terms have come into usage, which do not carry with them the opprobrium that was connected with these earlier names for the three general classifications of the mentally retarded, and which are at the same time more descriptive of the actual condition of the mental retardates they designate. The literature now speaks of (1) the educable mentally retarded, (2) the

trainable mentally retarded, and (3) the totally dependent mentally retarded.[7] This is a classification that emphasizes educational characteristics primarily, and the terms are almost self-explanatory. A slight variation of this terminology classifies the mentally retarded as (1) the educable mentally handicapped, and (2) the severely mentally retarded. The severely mentally retarded are in turn then classified as (1) trainable mentally handicapped and (2) the very severely retarded.[8] The National Association for Retarded Children emphasizes social rather than educational potentialities and uses the following classification: (1) the "marginal independent", (2) the "semi-dependent", and (3) the "dependent" retarded. However, these terms designate virtually the same classifications as the terms "educable", "trainable", and "totally dependent."[9] Both Kirk, Karnes, and Kirk[10] and Morvin A. Wirtz[11] describe the characteristics of the individuals in these three classifications at some length, and for that reason it would seem unnecessary to discuss these terms here beyond saying that the educable mentally retarded are individuals who can achieve academically in a limited fashion, and that they

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[7] Kirk, Karnes, and Kirk, op. cit., p. 8

[8] Morvin A. Wirtz, op. cit., p. 496

[9] Kirk, Karnes, and Kirk, loc. cit.

[10] Ibid, p. 8-10

[11] Morvin A. Wirtz, op. cit., pp. 496-497

grow mentally at about one-half to three-fourths the rate of average children and have intelligence quotients of about fifty to seventy-five. The trainable can learn little academically, but can be trained in self-care, socialization, and become economically useful to a limited degree. They grow mentally at somewhat less than one-fourth to about one-half the rate of the average child. The totally dependent, or very severely retarded, children cannot learn academically and the amount of self-care and socialization that they can acquire is almost nil, and in the most severe cases entirely so. They are and will remain completely dependent.

In this study the terms educable, trainable, and totally dependent mentally retarded will be used.

Procedures

The difficulties which are described in this study as factors which tend to interfere with the adequate home training of the pre-kindergarten mentally retarded were not arbitrarily chosen. When one has daily contact with many retarded individuals, reads their social histories, reads the literature on the subject of mental retardation, and at the same time has opportunity to counsel with and interview the parents of retarded individuals, it soon becomes apparent that there are certain factors operative that tend in many cases to make the early home training of these individuals less than adequate. As an example of the fact that at

least four of the five factors studied in this report have suggested themselves to others is an article by Michael J. Begab entitled, "Factors in Counseling Parents of Retarded Children". In this article he mentions the parents who are so overprotective and emotionally involved with their problem children that they refuse to face the reality of the child's limitations; he mentions the fact that these parents are frequently exposed to all kinds of pressures from relatives and friends, who feel free to judge, criticize, advise and condemn with very little or no information about the subject of mental retardation and thus cause still more confusion and emotional involvement of the parents; he speaks of the parents "who run frantically from one medical expert to another seeking miracle drugs, elaborate surgery, chiropractic treatments or other "cures" in the hope of making the child "normal"; and finally he also mentions the fact that while some parents do not realistically recognize their child's limitation, others do not realize that their child, though limited, nevertheless does have abilities which can be developed and used to the betterment of the child's lot in life and the parents' satisfaction and peace of mind.[12] Norma L. Bostock, the mother of a retarded child, in a paper delivered on Parents Panel at the Seventy-ninth Annual Meeting of the American Association on Mental De-

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[12] Michael J. Begab, "Factors in Counseling Parents of Retarded Children". American Journal of Mental Deficiency, Jan. 1956, pp. 515-524.

ficiency says that for her and for other parents, when they are confronted by the fact that their child is retarded, have found it necessary "first to face it, then to understand it, then to accept it, and finally to seek some methods of solving it". In this paper she speaks especially of the necessity for and the benefit of a program of parent education, so that parents can be better fitted to discharge their very special responsibility in the task of rearing retarded children.[13]

From daily contact with a large number of retarded individuals over a period of almost three years, from contacts and interviews with parents, from the study of case histories including social histories of the patients at a large training school, and from the reading of the literature on mental retardation the five following factors which tend to interfere with the home training of mentally retarded children have emerged: (1) the search for a medical or surgical (or, even, magical) "cure" in the hope of making the child "normal" by these means; (2) the fact that parents, who have little or no training in psychology or educational methods, and usually have no one to advise them, would be unaware of the degree of trainability of their child and might expect either too much or too little of the child; (3) that siblings, relatives, neighbors, friends, and acquaintances have unwittingly been

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[13] Norma L. Bostock, "How Can Parents and Professionals Coordinate For The Betterment of All Retarded Children?" American Journal of Mental Deficiency, Jan. 1956, pp. 428-432.

an interfering, frustrating, and discouraging influence and have brought undesirable pressures to bear upon the parents and thus have served to distract the parents from devoting necessary thought and effort to the training of their child; (4) that the parents have been so emotionally involved for various reasons that they could not accept fully and intelligently enough the responsibility for training their retarded child, and finally (5) the fact that there are always some parents who are either mentally incapable of realizing their responsibility or too callous and are therefore indifferent to the child's welfare. In this study these five factors are designated, therefore, as (1) the hope for medical or surgical cure, (2) the awareness of the child's trainability, (3) difficulties with other persons due to the child's condition, (4) the emotional factor, and (5) the factor of indifference.

With these five factors known to be operative at least to some extent in the families of many retardates it was necessary to choose what promised to be a good method of obtaining information as to whether one or more of these factors had interfered with the home training of fifteen selected trainable children. Since the awareness of the presence of these factors had come from personal contacts with the retarded, from reading reports of psychological evaluations and social histories found in the case files of the institution, and from contacts with parents, it seemed best to use all of these sources of information, and first collect all data to be found at the institution and then supplement this by means of

face to face interviews with the parents, especially the mothers of the selected subjects.

In order to assure complete and uniform information in all cases an information and interview guide was written and sufficient copies were made so that a separate guide could be filled in for each case studied. This information and interview guide consisted of five parts. The first part called for preliminary data about the present status of the patient and pertinent general information about the parents, such as their educational attainments, their social and economic status, and whether there is a history of mental retardation or mental illness in the family. The following four sections, to be filled in partly from data already available in case files, were designed to serve as a guide in eliciting information about the presence or absence of four of the five factors chosen for study. The fifth factor, that of indifference, has no section in the guide, because it was felt that the questioning concerning the first four factors would sufficiently indicate whether this factor had been operative or not.

The subjects selected for study are the parents of mental retardates now resident at Winfield State Training School of whom it is now certain that they belong in the classification designated as the trainable mentally retarded and who were born between the beginning of 1935 and the end of 1945. This was about the youngest age group that could be selected, because it was necessary to be absolutely certain that they actually are trainable, and also

because it was necessary for the purposes of the study that they be individuals who had been in the home a sufficiently long time in their lives to have had opportunity to receive home training. The parents of trainable mentally retarded children were also selected as subjects because this type of retarded constitute a larger group at the Winfield State Training School than do the educables, and also, because the educables who are between the ages of six and twenty-one years are now being cared for at the Parsons State Training School. These were the criteria for selection.

During the interviews the questions in the guide were not always followed consecutively, nor were all of the questions always asked. The person being interviewed was invariably allowed to take the lead, and only when it have become apparent that the topic being discussed was exhausted and it had become evident that the factor being discussed had been either present or absent was the next factor introduced. The interviews did not invariably follow the guide consecutively from one section to the other, because on more than one occasion the person being interviewed would begin speaking about highly charged emotional material in connection with one of the other factors, or would start speaking of the relationship of the family with neighbors of friends while talking about difficulties in training the child, or there were other similar variations. It was felt that this spontaneous expression of thoughts, feelings, observations, and opinions should not be interrupted or stifled in any case by an adherence to the guide.

None of the individuals interviewed proved to be reticent. All were willing to talk about their experiences and feelings rather freely. The interviewer could even make an estimate in almost all cases as to whether a factor, or several factors had been very much in evidence, only moderately so, or just present.

After each interview, and while the details of the interview were still vivid, the guide was as completely filled in as possible, and any additional information that seemed pertinent was noted either on the margin of the appropriate section of the guide or on the back of the page. As soon as possible after the interview the data collected on the guide were then summarized, and these summaries were kept together with the completed guides, and from this material the absence of presence of each factor was recorded and an estimate as to whether the particular factor was very much in evidence, whether it was only moderately so, or just present was made. In order to help estimate, a table was made listing the five factors horizontally and the fifteen cases vertically and after each case one "x" was placed if the factor under consideration was merely present, a double "xx" was placed if the factor seemed to be moderately in evidence, and if a particular factor was very much in evidence a triple "xxx" was placed.

CHAPTER II

WHAT THE STUDY REVEALED

In all but one instance it was surprisingly easy to obtain the information sought. Mothers generally, and when the fathers could be present, both parents seemed very pleased to have the opportunity to unburden themselves. Most interviews were from one to one and one-half hours in length and nearly all of them had to be tactfully terminated by the interviewer. One received the distinct impression that these parents had not on very many previous occasions felt free to speak of their retarded children and about the difficulties and problems, the disappointments, frustrations, and sorrows caused by the child's advent into the home, because they had not felt that they would be understood. The fact that the interviewer is the chaplain at the training school in which their children are now resident and presumably knows something about retarded children, and, at least at second hand, about the problems and feelings of their parents, was a very definite advantage.

General Conditions Prevailing

The majority of these families can be described as average American families. Most of the fathers are steadily employed, and their earnings range from slightly below to slightly above the av-

erage annual per capita income in the United States. There were no professional people in this group, and there were also no farmers. With two exceptions the homes were modest but adequate, in good, clean neighborhoods, with well kept premises and neat and sanitary interiors. One dwelling could hardly be called anything but a hovel. The other was a house in fairly good repair in a good neighborhood, but untidy housekeeping was everywhere in evidence. This mother is able to live in this kind of house because she is supported by county welfare and because her son-in-law, who lives with her, shares the rent. In only one home was the mother employed outside the home during the period when the retarded child was still in the home. Perhaps the educational level attained by these parents would average slightly below the average for the total population. Their average aspirations and hopes for themselves and their children are typically American. They are, on the whole, in no way exceptional people except for the fact that it was their lot to become parents of retarded children.

It is, perhaps, noteworthy that in this small sample there is only one case of mental retardation which seems to be clearly endogenous. In the other case where the parents are evidently submarginal there is evidence that both endogenous and exogenous factors contributed to the retardation. In every other case accident and trauma either before, at, or after birth was the cause for the retardation.

With the exception of two cases all of the parents sub-

scribed to the principle that bringing a child into the world places upon the parents the responsibility for the care and education of that child. None of them, with the exception of the same two mothers, failed to explain the circumstances and difficulties which finally persuaded them to place their children in an institution. This evident need to justify their action reveals at least a lingering doubt as to the advisability of that action, and in one or two cases a feeling of guilt was in evidence. All of them with the same two exceptions showed evidences of a sense of failure in not having been able to keep their child at home. All of the parents expressed love for their retarded children, but in two cases the remainder of the interview made it quite clear that this was said because one usually does express love when speaking of ones children, and in one additional case there was evidence that made it seem that there was actual aversion to and rejection of the retarded child on the part of the family in spite of the protestations of love.

A detailed examination as to what was found concerning the five factors which would tend to interfere with the home training of these retarded children, and whether and how, or how much, they did interfere follows.

The Hope for Medical or Surgical Cure.

This factor was strongly in evidence as interfering with the training of the child in only three cases, present in one, and

moderately in the fifth. This statement is not meant to convey the idea that in the remaining ten cases there was no effort on the part of the parents to obtain medical and surgical help in the hope of a cure. There was some of this in eight of these ten remaining cases, but it was felt that this was not enough of a preoccupation on the part of the parents to have been a factor which would cause them to neglect the training of the child.

In the first of these three cases, in which the search for a medical cure was a strong interfering factor, the child was born while the father was on over-seas duty with the navy. The child's retardation is the result of congenital agenesis of the brain due to birth trauma. The mother became aware of the child's retardation at age thirteen months. When the father returned from sea duty he was very bitter toward his wife and accused her of negligence, and attributed the child's condition to this alleged negligence. Various doctors were consulted, and finally they took the child to an osteopath who treated her for more than a year. The father would not be convinced that the child could not be helped medically. Finally they took the child to the Institute of Logopedics in Wichita and were referred to the guidance center in the same city, where a psychologist examined her. Since one of the doctors who had seen her had told the parents that there was not much hope of teaching the child anything her bodily needs were provided for and no real training or program calculated to stimulate what mental ability she did have was undertaken.

The second case in which the parents' preoccupation with medical treatment almost completely diverted their attention from any thought of how to train the child was that of a boy. At his birth labor was long and there was a breach presentation, and the baby, when born, had a broken nose, numerous bruises, and was black and blue. On the third day the child had a sinking spell, was cold up to the hips, and was not expected to survive. He then proceded to develop almost within normal limits. Weight gain was normal. He sat alone at six months, walked alone at fourteen months, said the first words at about eighteen months, achieved bowel and bladder control at about two years, and could feed himself at about this time also. Approximately at age two years he had a bilateral mastoiditis and infection of the middle, and, perhaps inner, ear, which was drained at the time. After this first attack there were occasional recurrences until he was four years old, when a bilateral mastoidectomy was done. After the first attack the boy could no longer speak, did not control bowels and bladder and did not feed himself, and now failed to regain the lost abilities. The boy's father, who is a skilled airplane mechanic, said that he has spent thousands of dollars for medical attention for his son, including a six months course at a chiropractic clinic, which at one time made the claim that they could cure any type of mental retardation. Since no one ever mentioned that this boy needed special training nothing was done.

The third case in which this factor was operative in diverting the attention of the parents from the possible value of home training is that of a mongoloid girl who is now fourteen and one-half years old. In spite of the fact that diagnosis was clear and firm before the end of the child's first year of life, these parents were unable to accept the fact that their daughter would not develop normally or that there was no possibility for a medical cure. Six medical doctors were consulted, and when none of them gave the parents any encouragement, they took the child to an osteopath, who treated her with pituitary extract three times weekly for a period of about two years. When this treatment did not yield satisfactory results they next took her to a chiropractor, but since the child seemed worse after each treatment, this was soon discontinued. These parents never gave the possibility of training this child a thought. They "just went along as if nothing was wrong", according to the mother, and the child did become a very serious behavior problem, which led to institutionalization.

In the fourth case in which this factor was operative it is quite evident that, while this factor did play a part, other factors were predominant. The patient is an attractive appearing fourteen year old boy whose birth and very early development were entirely normal. Not only were there no complications at birth, but he sat alone at six months, stood alone and is said to have used a spoon at nine months, and walked alone at eleven months.

Very soon after the boy began to walk he contracted measles accompanied by a "very high" fever, and after this illness he did not again walk until he was twenty-one months old. Other gains which he had made before this illness were also lost. He had to be retrained to use a spoon. He did not develop speech at all during the remaining years before being admitted to the training school. After his illness the parents took the boy to the Mayo Clinic at Rochester, Minnesota, to the Shriner Children's Hospital in St. Louis, and finally to the Menninger Clinic in Topeka. They seemingly could not reconcile themselves to the fact that their son would not again become well and like other boys.

The fifth case in which the search for medical cure was moderately in evidence is that of a boy who is now about fourteen years old. His parents became concerned about him when he was about thirteen months old because he did not seem to notice people and did not recognize his parents. However, in spite of the fact that he did not begin to talk and did not begin to do things for himself it was not until he was about three years old that they had him checked by the family physician and by a pediatrician. These doctors sent them to a children's clinic, and the clinic told them that the child's case was hopeless and that he would never attain more than a mental age of six years, and they strongly recommended that he be sent to a state training school. The parents refused to accept this recommendation. In fact they refused to believe that the child was as severely retarded as they

said he was. According to the father there followed a series of consultations with other doctors, and when they finally failed to receive any encouragement from these doctors, and they heard of the Institute of Logopedics in Wichita, Kansas, they moved from Indianapolis, Indiana, where they lived at the time, to Wichita, so that their son might receive treatment and training there.

Awareness of The Child's Trainability

The question we hoped to answer here was, "how many parents are aware of their child's trainability?" There are four possibilities here. The first is that the parents are not aware of the child's full potential because the child's limitations are too painfully evident, and therefore tend to make a minimum effort. The second is that the parents, in spite of the child's very evident limitations, refuse, or at least fail, to take them into proper account, and expect more of the child than he is able to do. The third possibility is that the parents are quite well aware of both the child's abilities and limitations, but do not sufficiently realize what this demands of them in the way of special training and teaching and what methods are likely to prove most practicable. The fourth possibility is, of course, that the parents do realize the child's trainability, both his abilities and limitations, and have some practical ideas as to how to go about teaching the child.

As might have been expected, none of the parents were found

to have a real understanding of the special problem in training presented by their retarded child. Since this is true, it is best here to briefly describe each case.

The first mother interviewed said, "I didn't think there was much hope." In answer to the question, "What advice did you get for training your child?" she answered scornfully, "make _____ eat raw carrots and celery!"

Another mother said that she was not aware that a child like hers could be helped and tried to train her just like other children. Nevertheless this mother evidently was able to sense somewhat when the child was ready to learn certain things and did not as a rule expect too much of her child. She made rather too little effort at training.

A third mother made no special effort at all.

The fourth said, "We just went along as if nothing was wrong," and this was literally true to some extent. The child was often expected to behave as if nothing was wrong, which was an impossibility for her, and when she would react by screaming, kicking, getting stubborn or struggling, the mother would yield. "I could never say no to her", the mother said. When the child was put into a room with a little gate on the door where she could not do any harm she would go through her entire repoirtoire of bad behavior and the mother would let her out.

The fifth mother just had no idea how to go about training any child.

The sixth did not make much of an effort to train her child. What training the child did receive was initiated by the father, and when the mother did not try to follow his directions, he sent the child to a private day school for retarded children for about a year.

Neighbors told the seventh mother interviewed that the best thing she could do would be to place the child in an institution because there was no use in trying to teach her anything. Nevertheless this mother did try to train her daughter by encouraging her to try to do various things, but did not expect more of her than she was able to do. There was, however, not enough nor the right kind of encouragement.

The eighth mother was not even concerned about properly feeding her child, let alone trying to train him.

The ninth mother made no effort at all to really train her daughter. This mother was preoccupied with what she considered her failure as a woman. Before her daughter was admitted to the training school she had given birth to two more defective children, both the totally dependent type.

The tenth mother had no time to devote to her retarded son. She had to earn a living for her other children, so the retarded child was placed with a couple who were willing to feed and care for him.

The eleventh mother interviewed complained rather bitterly that friends were ready with much advice that was well meaning but

quite beside the point because they had no understanding of her problems. She admitted that she had, perhaps, given in to her son too much. She said that she did much coaxing and begging to get him to comply with her wishes, but that he is an extremely "high strung" boy and she was afraid to "cross him". She is herself an extremely nervous and tense individual.

It is quite evident that the twelfth mother interviewed did not give her daughter any special training. This mother did not quite fully comprehend that both of her daughters were retarded.

A "child specialist" was said by the thirteenth mother to have told them that there wasn't very much that they could do. Speaking of training the child in self-help she said that she did not make any special effort because it was much quicker and easier to do things for him.

The fourteenth mother interviewed tried very hard to train her son for a period of three years before she and her husband would admit even to themselves that there must be something very wrong with their child's ability to learn. An example of her methods of training is the fact that she would make the child sit on the toilet seat for an hour or so at a time when he was less than one and one-half years old, and when he would begin to cry she would misinterpret the crying as evidence that the child had pain and would then give him an enema while he was kicking and screaming.

Speaking about training her retarded child the last mother

who described her experience said, "We just blundered along." No real effort was made to train their retarded son. His older brothers played with him and the atmosphere of the home was a happy one. This was indeed a fortunate circumstance, but this was a case of too little training.

The Social Environment

The retarded child and his parents, no matter how much the parents try to keep to themselves, are a part of the social scene. The child may have older or younger siblings, and the family has relatives, neighbors, and friends, and they cannot escape from contact with these people, try as they may. Yet, because the retarded child is different, especially in those abilities that make real communication between individuals not only impossible but also pleasant, real difficulties are liable to arise. It was not the purpose of this study to try to discover how many such difficulties arise under these circumstances, but only whether and how frequently this type of difficulty had an adverse effect upon the home-training of the retarded children in these fifteen families.

It was found that in these families the social environment was not as much of an interfering factor as had been originally suspected. Four out of the fifteen mothers interviewed mentioned some difficulties with other persons that could be said to have had an unfavorable influence upon their efforts to train their retarded children. In a fifth case this factor was very prominent.

One mother said that other children outside the home would at times mistreat her retarded daughter. As an illustration of what she meant by mistreatment she said that one time the boys of the neighborhood threw her daughter down in the snow and piled the snow in her face. The fact that they had this retarded child in the home kept other children from coming in to play with the normal siblings. She said that both of these problems discouraged both her and her husband, and made efforts at training seem more useless. This was one of the factors that caused the parents to apply for their daughter's admission to the training school.

Another mother said that the children in the neighborhood would often make fun of their retarded child in the presence of her older brother, and that frequently they would also make fun of the boy himself, because he had a retarded sister. The relationship between the siblings was excellent. "He worshipped her" until about a year before she was institutionalized. During this last year she would become very angry at him and throw things at him. This was a factor contributing to their decision to send the child to the training school.

A third mother told a story almost identical with the one above. Again there was an older brother whose relationship with the retarded younger sister was excellent. He was very fond of her and played with her regularly. But the same difficulties with other children developed and with the same results.

All three of these mothers had only praise for the attitude

of neighbors, relatives and friends toward them and their retarded children.

A fourth mother, however, had a somewhat different experience. She said that she could not permit her child to play with other children of the neighborhood because he was unpredictable and because the neighbors did not want him to do so. She also complained of much well-meant but discouraging advice given by her neighbors and friends including the advice to place the child in an institution because his case was hopeless.

This factor was very prominent in a fifth family. Here there was a brother four years the retarded boy's senior. He would have little to do with the retarded sibling and as time went on and the retarded boy's behavior became more and more destructive and aggressive the relationship between the two became one of mutual hate. The neighbors would not permit this boy to play with their children, and the parents were also afraid to permit this, and, as a result, he was kept in a fenced-in back yard where he would "just pace back and forth."

The Emotional Factor

The fact that some parents are so emotionally involved with their retarded children that they seem to be unable to face the reality of their childrens' limitations has been mentioned. This is sometimes a genuine love for the child combined with the false notion that the only way they can help him is to overprotect him.

Sometimes, however, it is a deep seated inability to accept and love the child. In order to deny, mostly to themselves, that this is so, and to rid themselves of guilt feelings that accompany this inability, some parents overprotect the child. Other parents insist that the child must become just like other children. They grasp eagerly for any means that they think might make him "normal," and insist that he behave and learn "just like other children." At times, too, husbands and wives quarrel with each other, each blaming some disability within the other for the child's condition. And at times they cannot agree as to the proper rearing of a child like this. Then there is also the possibility of relatives taking a hand, creating emotional problems by their lack of understanding of the situation. There can be many types of unhealthy emotional reactions to the presence of a retarded child in the home which would tend to make it very unlikely that the child will receive its just dues. All of these come under the heading: The Emotional Factor.

This factor was present in four of the families studied. One mother said that when the doctor told them that their child would be retarded they could, in fact, would not at first accept that fact. Later, in spite of everything, they were never able to fully reconcile themselves to their daughter's condition. In the second family there was a gradually growing realization of the son's retardation which they tried to deny to themselves and which they tried to eliminate by taking him to doctors in the hope of a

cure. The third mother, who is now a widow, said that she often wondered why this should happen to her, and wondered whether God could be punishing her because of some misdeed. She also said that both she and her husband wondered whether this was a hereditary condition, and that her husband sometimes accused her of having cheated before marriage by not telling him that she might give birth to this kind of child. Their disagreements sometimes became rather serious. The fourth mother said that it "hit both me and my husband hard." She too had some misgiving about whether this could be divine punishment. During the time that they still had their retarded son in the home their two other children had some sort of trouble with their eyes, and she said she often wondered whether she were capable of giving birth to normal children.

There were five families in which the emotional factor was quite prominent. The first of these families has been mentioned before. The retarded daughter was born while the father was in the navy and on sea duty. When he returned he blamed his wife for not having taken proper care of herself during the period of gestation and for not having consulted a specialist soon enough after the child's birth. He would not admit that nothing could be done for the child to make her normal. The child's retardation was the cause for almost endless quarreling between these parents and their marriage finally ended in divorce.

Another mother said that when their family physician told them that their child was retarded they felt that he must be

wrong, that this simply could not happen to them. They both thought that God was punishing them and thought that it was unfair. The father "just knew that she would be all right", and in order to prove it he went to a great deal of expense in seeking a "cure". This child is a mongoloid, and this makes the father's action rather significant.

A third mother was almost obsessed with the idea that she must give birth to a "normal" child in order to prove her womanhood. She persisted in having children. The first three were all retarded, the oldest being a trainable retarded child, and the other two totally dependent children. She was then divorced and remarried and gave birth to three still-born children.

The fourth of these mothers is a very nervous and tense individual. She said that when she was told that her son would be retarded she felt that it was unfair to her, and she felt angry and resentful. Later, when the child had become older, she felt ashamed of herself and her son when people would "stare" at them, and felt like shrinking out of their sight. This is noteworthy, because the boy is without stigmata and a ragher attractive looking boy. She also expressed much bitterness and resentment toward the neighbors, because they did not understand, and said that she often became very discouraged and depressed.

Finally there is the family who did everything conceivable for their retarded son. They were so concerned about doing something to make him well that they moved from Indiana to Kansas, so

they could send him to the Institute of Logopedics. They were determined that this boy must become "well" and have average intelligence. As has been pointed out, they did not seek any kind of help or advice until the boy was three years old, even though they admit that they became aware that something must be wrong with him when he was only thirteen months old. And when they did receive competent advice, they would not accept the diagnosis. They still insisted that he behave and learn like an average child. When the child's aggressive and destructive behavior became so bad that there was a relationship of mutual "hate" between the retarded child and his older brother and he could no longer be controlled they placed him in the training school. It is very possible that this is a case in which the parents themselves were not able to actually accept and love this boy.

The Factor of Indifference

There is always the possibility that there are parents who are to a greater or lesser degree unconcerned about the education and training of their children. There actually were three cases out of the fifteen studied where this was a factor. All of these mothers have been previously described in this report. One of the mothers, and the father was not much better, was so mentally retarded that she was incapable of having any concern for the training of her son. She did not even realize that it was necessary to feed him properly. Another mother was very much like this mother.

In her own fashion she loved her two retarded daughters, but was evidently not able to be concerned about their training. She did not appear to be aware of their mental retardation. There was evidence that the third mother is an individual with near average intelligence. She had completed the ninth grade and during the interview her vocabulary was good and her sentences were well constructed. She expressed concern about her son's physical well-being and the wish that he might behave like other children, but the thought of making an effort to teach him to be more like other children had evidently not occurred to her.

CHAPTER III

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

In summarizing the findings of this study it should be noted that by far the most important single factor that prevented the parents from training their retarded children in the home as they should, and could have, is the fact that none of them had any real hope that anything could be accomplished nor any clear idea of how to go about it. Most of them tried to rear the retarded child as much as possible as if nothing was wrong with the child at all. A few didn't try any kind of training. Two were inclined to expect far too much of their retarded children. In only two instances can it be said that the parents sensed that the child should be taught when he had developed a readiness for the new skill or new knowledge.

The next most important factor in preventing the parents from undertaking real training of their children was found to be the emotional factor. Yet this was operative in only nine out of the fifteen cases studied, and in only five was it of real importance. In two cases it resulted in making the child a real behavior problem.

Next in importance was the search for a medical or surgical

cure. Yet, in only three cases was this factor very much in evidence. In one it was moderately in evidence, and in the fifth it was merely present.

The social environment, as a factor that would tend to interfere with the home training of retarded children was not prominent in these fifteen families. In four it was present but not of great importance. In only one family was it of real importance.

Indifference that completely prevented any kind of home training was in evidence in one family, and moderately in evidence in two others. This was in two cases due to the fact that the parents themselves were not mentally capable of realizing that training and teaching are a necessary part of rearing children in general and in the third case the reason for indifference was simply carelessness or irresponsibility.

In order to assist somewhat in visualizing the frequency with which each of the five factors discussed in this study appeared, and the relative importance of each in interfering with the home training of retarded children in the fifteen families, which were the subjects of this study, the table on the following page is presented. It should be stressed that the "x" used in the table is not to be interpreted as in any way denoting quantity, nor is it to be understood that when "x" is placed this means that there was only one-half as much of the factor present as when "xx" has been placed. An "x" denotes that the factor was present and

had some adverse effect upon the training of the retarded child. A double "xx" means that the factor was moderately in evidence and was more prominent in interfering with the child's home training. A triple "xxx" means that a factor was very much in evidence and interfered very much with the home training of the child.

Table

PRESENCE OR ABSENCE OF FIVE FACTORS WHICH TEND TO INTERFERE WITH THE HOME TRAINING OF PRE-KINDERGARTEN TRAINABLE MENTALLY RETARDED CHILDREN IN FIFTEEN FAMILIES

Case No.	Medical	Training	Social	Emotional	Indiff.
1	xxx	xxx		xxx	
2		x	x	x	
3	xxx	xxx		x	
4	xxx	xxx	x	xxx	
5		xx			xx
6		xx	x		xx
7		xxx		x	
8		xxx			xxx
9		xxx		xxx	
10		xxx			
11	x	xxx	x	xxx	
12		xxx			
13		x		x	
14	xx	xxx	xxx	xxx	
15		xx			

x signifies that a factor was present
xx means that a factor was moderately in evidence
xxx signifies that a factor was very strongly in evidence.

Some Conclusions

Since factors influencing the home training of pre-kindergarten trainable retarded children in only fifteen families have been studied, any general conclusions drawn from this report could be questioned because the sample is not large enough to be repre-

sentative. The conclusions drawn from this report are, therefore, to be understood as limited by this consideration.

The one finding that stands out in this study is the fact that none of the parents was found to have an adequate conception of what the training of retarded children involves. In two families, it is true, the training of the retarded children was somewhat superior to that given in the others, because these parents realized that some training should be undertaken and also sensed that their retarded children would not be able to learn as readily as most children. Even in these cases, however, the training proceeded on a strictly trial and error basis. It is evident, then, that the fifteen children who came out of these families did not have an adequate opportunity to develop their limited potential. Compared with average children they were at a double disadvantage. Their first disadvantage was the fact that they were retarded. Their second disadvantage was that their parents did not understand their needs as well as parents generally understand the needs of average children. Consequently they could not receive the kind of training they needed in order to develop.

It should be pointed out that, with the exception of three cases, the failure of these parents to understand the problem involved in training their retarded children was not due to any inferiority in them. This failure was due to the fact that they had no sources of helpful information. The physicians, psychologists, and others who were consulted almost always emphasized the limita-

tions of these retarded children. The counsel most frequently given was that since the child would not be able to progress beyond a certain level the best solution to the problem would be to place the child in an institution as soon as possible. In these fifteen cases there seems to have been an almost total absence of the positive. No one seems to have told these parents that in spite of their severe limitations these children did have some assets that could and should be developed. It is certain that no one made any effort to give these parents any kind of information as to how to go about teaching and training their retarded children. From this we can conclude that twelve of these fifteen children would by now have been more socially competent and more economically useful than they are if the needed counsel and instruction had been made available to their parents.

An important and challenging question presents itself in this connection. Would the unrealistic searching for medical and surgical cures have been reduced, and would the emotional involvement of the parents have been less pronounced and better controlled if these parents had been given realistic counsel and workable information as to how to go about rearing their children? There are certainly some indications that this would have been so. There can be no doubt about the fact that these parents did not know what to do or where to turn when they began to suspect that their children were not like other children. When they were merely told what their children would not be able to do, but not told that

something could be done for them, this was a total tragedy which was too great for these parents to accept. It would seem that if the positive had been stressed there would have been less inclination to attempt to keep some hope alive by trying to prove to themselves that the counselor must have been wrong by seeking for some cure. Giving these parents definite hope that something could be done, even though that something must be limited, would have served to lessen the tragedy and given them something realistic to strive for. This would have made their very great misfortune seem much more bearable.

One additional point should be stressed here. Much mental and emotional growth that should have occurred in these children during the period of pre-kindergarten training in the home can no longer take place. Many good habits that they should have acquired during this period they will now no longer be able to acquire. The relationship of the very early environment and training of the child to the personality of the resultant adult is the same in retarded children as it is in normal individuals. To speak figuratively, a small, weak, and poorly laid foundation means a correspondingly limited superstructure. Some strengthening of a foundation with a consequent improvement in the superstructure is almost always possible, it is true, but the end result can never be as good as if the foundation had been well laid to begin with.

The implication of all this for the education of retarded children is obvious. The provision of special classrooms for re-

tarded children by the community is not sufficient. If these classrooms are to yield maximum results the children who are to be taught in them must first have the background of a home training that has been somewhere near adequate.

Some Recommendations

In view of what has been learned from this study it seems almost self evident that any recommendations made must take into account the very great need for providing parents of retarded children with information, counsel, and guidance that is comparable to that now available to parents of average children.

The very first thing that should be done is the establishing of some kind of program that would make early recognition and accurate diagnosis of all retarded children available everywhere in the state. At the time of diagnosis the parents should be informed not only about their childrens' limitations, but also about their assets. How this is to be accomplished is somewhat beyond the scope of this discussion. A beginning might be made by sending out clinical teams staffed so as to be capable of rendering this type of service. They should reach each area where no such services are now available at least once each year. In the course of time more permanent facilities of this nature could, perhaps, be established.

Early recognition and accurate diagnosis, however, should be only the beginning of the services offered to the parents of re-

tarded children. Some kind of assistance should be given to every parent of a retarded child in the actual month by month rearing and training of the child. Perhaps the most feasible method of accomplishing this would be to provide home teachers well qualified in the field of special education who would visit each home where a retarded child is found at regular intervals. Their function would not be to teach the retarded children themselves, but rather to instruct the parents, especially the mother, in the best known methods of training retarded children. If special difficulties should arise between regular visits such home teachers could be called in by the parents for consultation.

Every home teacher should be made responsible for keeping an accurate and complete record of every case served. These records should in time provide much information that could be used to improve the instruction of the parents.

Parents of retarded children should everywhere be encouraged to meet with each other for mutual encouragement and exchange of ideas, and for the purpose of learning from experienced professionals such as teachers, psychologists, physicians, and others more about mental retardation in general and about methods of teaching and training their retarded children in particular.

Books, pamphlets, periodicals, and articles in popular and widely read magazines, that are designed to give parents of retarded children encouragement, information, and advice that would be helpful to them in their difficult task should be disseminated as

widely among them as possible. At the present time there are a number of good publications in existence. More should be added.

There should be an intensification of the present program of informing the general public of the facts concerning mental retardation of all degrees of severity. It is true that this study indicates that the social environment did not interfere with the home training of the retarded in very many instances. It cannot be said, however, that neighbors, friends, and relatives were really understanding and helpful. The parents who were interviewed found themselves pretty much alone with their problem. Many people pitied but few understood and still fewer did anything to help. A program of familiarization would go far toward changing this state of affairs.

In conclusion it should be stressed that residential training schools are not the answer to the great and growing problem created by the retarded children in our nation. The number of retarded children in the nation is too large to make it possible to serve more than about ten per cent of them in this way. There is an awakening awareness of mental retardation in medical circles, and research contemplating an eventual reduction in the incidence of the condition is being planned. This is all to the good, but results from this effort are bound to be meager for some time to come. For the present, therefore, the responsibility of education to the mentally retarded must be a large and important one. The task of education is to teach and train the mentally retarded so

that at least ninety percent of them can become socially competent and economically useful to a degree sufficient to make it possible for them to remain in their own homes and communities. This is not a goal merely to be hoped for, it must be attained. Public education is for all the children of all the people commensurate with their needs. Teaching and training the mentally retarded in accord with their needs is, therefore, also the responsibility of public education.

APPENDIX A

INFORMATION AND INTERVIEW GUIDE

PRELIMINARY DATA

THE PATIENT:

Name_____Bldg____Born_____

Admitted_____Age at admission_____C.A._____

I.Q._____School_____Work assignment_____

Diagnosis_____

Behavior_____

_____

Progress_____

_____

_____

_____

Siblings: Older B___G_____, Younger B_____G_____

THE PARENTS:

FATHER:

Name_____Address_____Born____R__

Education: Grades_____H.S._____College_____Other_____

Married_____Divorced_____When_____Widowed_____

Children:B____G____How many deceased?_____Cause(s) of death_____

_____

Any defectives? (Not our patient)_____

Military service_____Length_____Duties_____

Highest rank_____Employment_____

How steady_____Approximate income_____

How long at present job?_____this type of work_____

Remarks on personality_____

Deceased?_____Casue of death_____

Any mental illness or retardation in parents' family?_____

Describe_____

MOTHER:

Name_____Address_____Born___R___

Education: Grades___H.S.___College_____Divorced?_____

Children: B___G___How many deceased? _____

Cause(s) of death_____

Any defectives? (Not our patient)___Describe_____

Employed outside home?___When_____Duties_____

Wage_____Remarks on personality_____

Any defectives in parents' family?_____Describe_____

_____

INFORMANTS:

Relationship to patient_____Signs of tension?_____

Anxiety?_____Guilt?_____Embarrassment?_____Hostility?_____

Confusion?_____Recall ready?_____Hesitant?_____

General rapport_____

THE HOME:

Type_____No. of rooms_____Neatness?_____

Neighborhood_____Premises_____

I. HOPE FOR MEDICAL OR SURGICAL CURE

1. Mother's health during pregnancy_____Duration____

   Labor: Length_____Difficult?_____Presentation_____

   Instruments?_____Head injuries?_____Birth wt._____

   First cry delayed?____Blueness?____Other difficulty?_____

   Breast fed?_____Take food normally?_____

   Excessive crying?____Before feeding?____Convulsions?_____

   Describe_____

   Formula trouble?_____When weaned?_____

2. When did you become aware of child's retardation?_____

3. To whom did you go for information?_____

4. What were you told?_____

5. Give you any hope that child could be cured?_____

6. Did you believe him?_____

7. Did you go to other doctors?_____

8. Can you list them and tell what they said?_____

   _____

9. Did you try an osteopath?____What did he tell you?_____

10. How long did he treat the child?____Progress?_____

11. Did you tray a chiropractor?____What did he say?_____

12. How long did he treat the child?_____Progress?_____

_____

13. Did you try any other kind of cure?_____

_____

II. AWARENESS OF CHILD'S TRAINABILITY

1. Did any one tell you that it was useless to try to train your child?_____

2. Anyone tell you he might be trained at home?_____

3. Tell you how to go about it?_____4. What are some of the hints or instructions you received?_____

_____

5. Baby's progress: Gain in weight?_____When sit alone?_____

Pull self up in crib?_____Stand alone?____Walk?_____

6. What did you do to encourage walking?_____

7. When did child say first word?_____What was it?_____

Did you try to teach speech?____what did you do?_____

_____

When did you begin this?____What did you do when child did not respond?_____

8. When did you begin toilet training?_____

Why at this time?_____

When did he achieve toilet training? Day?____Night?_____

What did you do to train?_____

What did you do when he had accidents?_____

9. When did child begin feeding self?____Use spoon?_____ Did you try to train?_____What did you do when child was Messy?_____

10. Did you try training child to dress self?_____ When did you begin?_____Did you try to teach him to unbutton buttons?_____Button them?_____Untied shoe?_____ Tie shoes?_____Did you feel impatient when he failed?_____

11. Did child play with toys by himself?____With what?_____ Did he play with other children?_____When?_____

12. Did child ever have temper tantrums when you tried to teach?__ Scream?___Kick?___Get limp?___Pull away?___Struggle?_____ Hold breath?___Frown?___Get stubborn?____Strike?_____ Bite?___Destroy things?___Apathetic?___Tear clothing?____

13. In what way did you correct child?_____

14. Was child easily managed?_____Did he ever show special pleasure?____At what?_____

15. What else did you try to teach the child?_____

_____

III. THE SOCIAL ENVIRONMENT

1. How did child get along with siblings?_____

2. Did they play with child?___Describe_____

_____

3. Did they try to show him things?_____

4. Did they feel they had to protect him?_____

5. Were they ashamed of him?_____

6. How did other children treat this child?_____

7. What was their attitude toward your other children?_____

8. How did your neighbors treat you?_____

9. How did they treat your retarded child?_____

10. Did he get into difficulties with neighbors?____Describe_____

_____

11. Did your relatives accept you and your child?_____

12. Did your husband's relatives accept you and your child?_____

13. How did others treat you and your child?_____

14. Did others try to advise you?_____Criticize you?_____

15. Was this very distracting?_____

IV. THE EMOTIONAL FACTOR

1. Did you believe your doctor when he told you that your child was retarded?_____

2. Did you say, "This couldn't happen to me?"_____

3. Did you think God might be punishing you?_____

4. Feel this was unfair to you?_____

5. Can you describe how you felt?_____

_____

6. Did you think the child's condition was due to heredity?_____

7. That he inherited it from your family?_____

8. From your husband's family?_____

9. Were you afraid to have more children?_____

10. Did you ask anyone about this?_____

11. Did you think your husband might have cheated by not telling you of hereditary weaknesses in his family?_____

12. Did he think this about you?_____

13. Did child's condition cause disagreements between you?_____

14. How serious were they?_____

15. What did your relatives say about you having this child?_____

16. What did your spouse's relatives say?_____

17. How did this make you feel?_____

18. Were you ashamed of yourself or child in the presence of others?_____

19. Did they seem to stare and turn away when they saw you and your child?_____

20. Did you hide him when people came?____Feel like doing so?____

21. Did you withdraw from people?_____Spouse?_____

APPENDIX B

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